

**STATE OF INDIANA  
OFFICE OF MEDICAID POLICY AND PLANNING**

**Budget Analysis Report for Fiscal Years 2002 Through 2005**

*Presented to Budget Committee  
December 18, 2002*

## **EXECUTIVE SUMMARY**

The Office of Medicaid Policy and Planning (OMPP) is pleased to present the following information to the Budget Committee today:

- Update of Medicaid Expenditure Forecast for 2002-2003 biennium
- Forecast of Medicaid and CHIP Expenditures for 2004-2005 biennium
- Summary of Cost Containment Initiatives
- Major Risks to the Forecast

Appendix A presents the Medicaid and CHIP Expenditure Forecast for fiscal years 2000 through 2005 and specifies cost containment measures included in the forecast. The Medicaid forecast is developed on an incurred basis and is based on paid claims data through October 31, 2002.

Appendix B presents the projected Funding Sources and Expenditures for SFY's 2002 - 2005 and includes all the interfund transfers from other state agencies, which results in the forecasted expenditure for the Medicaid Assistance account appropriation.

The presentation and the remainder of this document will focus on the following key points:

- Medicaid will close the projected \$250 million budget deficit for the 2002-2003 biennium.
- Despite the "good" news for 2002-2003, the projected Medicaid Assistance growth rates for 2004 (6.4%) and 2005 (8.8%) present significant budgetary challenges. While overall Medicaid spending has been reduced, the rates of growth are still increasing significantly.
- OMPP's focus for the 2004-2005 biennium will be on making policy and program changes that will attempt to slow the rate of growth by improving health outcomes and providing care in a more cost effective manner, such as pharmacy benefit management, disease and case management and managed care for aged, blind and disabled recipients.
- While the focus will be on slowing the rate of growth, ongoing/additional cost containment will likely be required. Equally, if not more, important is that the cost containment that has been or will be implemented in the 02-03 biennium must remain in effect in the 04-05 biennium or forecasted expenditures will increase even more.

Table 1 shows expenditures and growth rates for SFY's 2001-2005 for total expenditures (state and federal), state share only and Medicaid Assistance account appropriation only.

**Table 1**  
**Forecasted Medicaid Expenditures – Total, State and Medicaid Assistance**  
**(Expenditures in millions)**

<b>Forecasted Expenditures</b>	<b>SFY 2001</b>	<b>Growth</b>	<b>SFY 2002</b>	<b>Growth</b>	<b>SFY 2003</b>	<b>Growth</b>	<b>SFY 2004</b>	<b>Growth</b>	<b>SFY 2005</b>
<b>Total (State &amp; Federal)</b>	\$3,386.0	11.7%	\$3,783.6	5.1%	\$3,976.7	9.0%	\$4,334.7	10.4%	\$4,783.6
<b>State Share</b>	\$1,278.9	12%	\$1,433.4	4.9%	\$1,503.6	8.8%	\$1,636.2	10.3%	\$1,804.7
<b>Medicaid GF Assistance*</b>	\$1,049.8	7.8 %	\$1,132.0	6.9%	\$1,209.6	6.4%	\$1,286.7	8.8%	\$1,399.5

\*This represents the Medicaid Assistance appropriation. It does not include Medicaid Administration. See detail Appendix B.

## **2002-2003 Biennium**

In December, OMPP projected a \$250 M budget deficit for the 2002-2003 biennium. Through a combination of cost containment, new revenue and enrollment and utilization changes, we expect to meet our goal of closing the deficit in order to operate within the biennium appropriation. Table 2 shows the reconciliation of the updated Medicaid Forecast for 2002-2003 biennium compared to the forecast presented in December 2001. (See Appendix B for additional detail.)

**Table 2**  
**SFY 02 & 03 Reconciliation**

	<b>SFY 2002</b>	<b>SFY 2003</b>
<b>Forecasted Expenditures – State Share</b>	\$1,433.4	\$1,503.6
<b>Interfund Transfers</b>	(\$264.9)	(\$279)
<b>New Revenue</b>	(\$62.8)	(\$27.7)
<b>Cash Adjustment</b>	(\$4.5)	(\$6.8)
<b>Additional Cost Containment / Adjustments<sup>1, 2, 3, 4</sup></b>	\$7.3	\$17.5
<b>Forecasted Expenditures - Medicaid GF Assistance</b>	\$1,108.5	\$1,207.6
<b>GF Appropriation</b>	\$1,132.0	\$1,209.6

1. The 2002 Additional Cost Containment/ Adjustment is composed of the \$6.8 million beginning balance deficit at SFY 2001 closeout and .5 million used to pay salaries for the disability expansion.
2. The 2003 Additional Cost Containment/Adjustment reflects additional expense estimated at \$17.5 M for pharmacy benefit management (PBM), disease/case management and managed care for aged, blind, and disabled recipients.

A summary of the major changes in the forecasted expenditures from the December 2001 forecast is provided in the table below.

<b>Major Changes</b>	<b>SFY 2002</b>	<b>SFY 2003</b>
December 2001 Incurred Forecast	\$1,482.6	\$1,685.6
Cost Containment	(\$10.8)	(\$121.8)
Enrollment & Utilization Changes	(\$29.0)	(\$53.0)
MRO, Waiver, Other Changes	(\$9.6)	(\$5.2)
Timing and Other Differences	(\$.2)	(\$2.0)
December 2002 Incurred Forecast	\$1,433.4	\$1,503.6

While enrollment continued to grow in 2002 and 2003, it did not increase to the levels that had been expected in the December 2001 forecast. Table 3 on the following page provides a comparison between the June 2003 enrollment as of the December 2001 Budget Forecast and the June 2003 enrollment as of the current budget forecast (i.e. December 2002).

**Table 3**  
**Comparison of June 2003 Enrollment Forecast**

<b>Aid Category</b>	<b>December 2001 Analysis</b>	<b>December 2002 Analysis</b>	<b>Increase / Decrease</b>
Full Medicaid – ABD			
Aged	57,076	57,669	593
Blind/Disabled Non-Dual (1)	63,032	59,161	(3,871)
Blind/Disabled Dual	33,213	32,746	(467)
Partial Medicaid – ABD			
Aged	9,053	9,721	668
Blind/Disabled	11,064	10,257	(807)
TANF and Related Children			
Adults	87,391	89,747	2,356
Children (2)	443,955	407,487	(36,468)
Pregnant Women	20,548	20,532	(16)
CHIP			
CHIP I	46,924	45,306	(1,618)
CHIP II	13,336	14,624	1,288
<b>All Aid Categories</b>	<b>785,592</b>	<b>747,250</b>	<b>(38,342)</b>

Notes: (1) The decrease in Blind/Disabled Non-Dual recognizes the lower than expected impact of Day case recipients.  
(2) The decrease in Children recognizes the impact of revisions to continuous eligibility resulting in a decrease of approximately 40,000 Children during FY 2003.

As the table shows, enrollment is projected to be 38,342 less than what was projected in December 2001. This is mainly due to lower than projected Day class recipients and the cost containment impact of eliminating the continuous eligibility coverage provision for children. In the December 2001 budget forecast, we had expected to have over 10,000 new enrollees by June 2002 in the Blind and Disabled populations due to the Day lawsuit, but we have updated enrollment to reflect that the final number of Day class members is only 3,871.

### **2004-2005 Biennium**

Total Medicaid expenditures (state and federal) are forecasted to be \$4.3 B for SFY 2004 and \$4.8 B for SFY 2005. This represents a 9.0% rate of growth for SFY 2004 and 10.4% for SFY 2005. As noted above, this is state and federal funds and includes expenditures for other state programs that are not part of the Medicaid Assistance appropriation.

## **ENROLLMENT**

### **A. Aid Category Trend Projections**

Enrollment is expected to account for approximately 4.2% of the projected overall increase. Enrollment values are calculated for ten separate aid categories. Table 4 illustrates historical and projected enrollment as of June for each fiscal year by aid category in total for the fee-for-service/primary care case management (FFS/PCCM) and risk based managed care (RBMC) populations. By the end of the 2004-2005 biennium, enrollment is projected to be 813,208.

**Table 4**  
**Summary of Historical and Projected Enrollment**  
**June FY Enrollment for FFS/PCCM and RBMC Enrollees**

<b>Aid Category</b>	<b>June 2002</b>	<b>June 2003</b>	<b>June 2004</b>	<b>June 2005</b>
Full Medicaid – ABD				
Aged	56,334	57,669	58,678	59,558
Blind/Disabled Non-Dual	54,812	59,161	63,893	68,046
Blind/Disabled Dual	30,591	32,746	35,039	37,141
Partial Medicaid – ABD				
Aged	8,683	9,721	10,693	11,335
Blind/Disabled	8,820	10,257	11,745	12,684
TANF and Related Children				
Adults	83,816	89,747	96,029	101,791
Children	423,756	407,487	422,768	434,394
Pregnant Women	20,774	20,532	20,635	20,738
CHIP				
CHIP I	40,972	45,306	46,778	48,182
CHIP II	10,074	14,624	16,964	19,339
<b>Total</b>	<b>738,633</b>	<b>747,250</b>	<b>783,222</b>	<b>813,208</b>

Table 5 shows the projected growth rate increase for the ten separate aid categories.

**Table 5**  
**2003-2005 Projected Growth Rates**

<b>Aid Category</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Full Medicaid – ABD			
Aged	2.4%	1.7%	1.5%
Blind/Disabled Non-Dual	7.9%	8.0%	6.5%
Blind/Disabled Dual	7.0%	7.0%	6.0%
Partial Medicaid – ABD			
Aged	12.0%	10.0%	6.0%
Blind/Disabled	16.3%	14.5%	8.0%
TANF and Related Children			
Adults	7.1%	7.0%	6.0%
Children	(3.8%)	3.8%	2.7%
Pregnant Women	(1.2%)	0.5%	0.5%
CHIP			
CHIP I	10.6%	3.2%	3.0%
CHIP II	45.2%	16.0%	14.0%
<b>Total</b>	<b>1.2%</b>	<b>4.8%</b>	<b>3.8%</b>

- **Aged.** Enrollment in the aged category is expected to increase by approximately 1.7% per year. The expected enrollment increase for the aged population is consistent with experience during the past three to five years. As with the general population, the population over age 65 has been growing in the Medicaid population; however, the impact of the Baby Boom

generation is not expected for another six to eight years and therefore this forecast does not include significant enrollment growth due to the expected increase in the aging population.

- **Blind/Disabled.** The Blind and Disabled recipients have been separated between Dual eligible (i.e., Medicare and Medicaid eligible) and non-Dual eligible recipients. In July 2002, a new program, called M.E.D. Works, was added to allow certain disabled working individuals to qualify for Medicaid. Lastly, the Blind and Disabled enrollment during fiscal year 2002 explicitly includes enrollees who were retroactively eligible during this time period due to the Day case settlement.

Overall, enrollment in the blind and disabled aid category is expected to increase by approximately 7.5% per year. Although the rate of increase in enrollment for the blind and disabled aid category is higher than historically experienced, it is consistent with the prior two years rate of increase. The rate of increase in enrollment growth has been attributed to Senate Bill 79 and the Day lawsuit, both of which made the eligibility criteria less restrictive.

- **Children and CHIP.** There was a significant decrease in this aid category between 2002 and 2003 due to the elimination of the continuous eligibility provision. The continuous eligibility provision automatically made all children eligible for Medicaid for one year. In July of 2002, this provision was eliminated and the eligibility renewal periods were made consistent with other assistance categories. Any child who continues to meet the financial eligibility criteria remains eligible for the Medicaid program. Based on historic member lapse rates prior to instituting continuous eligibility in July 1998 and preliminary enrollment data showing lapse rates from July 2002 to October 2002, this forecast assumes that enrollment in the children aid category will decrease by approximately 39,000 members.

For the 2004-2005 biennium, growth has been projected to average 3% per year for the Children population and 6.8% per year for the CHIP I and CHIP II populations. The projected enrollment growth for the Children and CHIP populations was developed from historic eligibility patterns and also takes into account that we may be reaching a ceiling in terms of eligible children. The forecast estimates we will have over 500,000 children (Medicaid + CHIP) in the program by June 2005.

The budget projection reflects an adjustment for the adverse selection associated with the change in the continuous eligibility provision. Adverse selection results from the propensity of sick children to stay on the program while healthy children tend to lapse at higher rates. This results in a population with higher per member costs.

- **Low-Income Adults.** The trend rate for adult enrollment has decreased from the 15% to 20% trend rate levels experienced between fiscal years 2000 and 2002. The growth for fiscal years 2003 to 2005 has been projected to range around 7% annual enrollment trend. During calendar years 2000 and 2001, the Medicaid program experienced enrollment growth in excess of 16%, believed to be largely due to the poor economy. During calendar year 2002, the Adult population has experienced a slow-down in the number of net new enrollees. The slow-down has been projected to continue during the biennium, but by doing so, assumes there will be an improvement in the economy.
- **Pregnant Women.** This aid category appears to have peaked at approximately 20,500 enrollees. As such, minimal change in Pregnant Women enrollment is expected in this forecast period.

## **B. Mandatory Risk Based Managed Care (RBMC)**

The 2001-2003 biennium budget bill mandated that Medicaid implement mandatory risk based managed care (RBMC) for most adult and children aid categories (referred to as TANF and CHIP populations) in certain urban counties. As a result of mandatory RBMC, there has been a significant increase in RBMC enrollment for the TANF populations during fiscal year 2002. Implementation was phased in by county/region as follows:

- April 1, 2002: Marion and Allen Counties
- July 1, 2002: Elkhart and St. Joseph Counties
- October 1, 2002: Lake County

## **C. Enrollment Sensitivity Analysis**

Enrollment growth and trend is a critical assumption in the Medicaid forecast. Due to its impact on the accuracy of the forecast, OMPP has performed an enrollment sensitivity analysis that models a 1% change in FY 04 and 05 enrollment assumptions used in the December 2002 Budget Forecast.

This sensitivity analysis considers the 1% change as an additive adjustment. For example, if we assumed an annual enrollment trend rate of 4%, the sensitivity analysis assumed an annual enrollment trend rate of 5% (i.e., 4% plus 1%). Additionally, the 1% change in the enrollment trend was assumed for each of the two fiscal years, 2004 and 2005. Therefore, if we assumed an annual enrollment trend rate of 4% in 2004 and 3% in 2005, the sensitivity analysis assumed an annual enrollment trend rate of 5% in 2004 and 4% in 2005.

The analysis indicates that a 1% change in total enrollment trends will increase the biennium budget by \$54.9 million (state and federal) or \$20.9 million (state). For an individual population, the Blind and Disabled-Non-Dual population has the largest potential impact over the biennium – adding \$16.0 million (state and federal) for each 1% annual change in enrollment.

We also performed the sensitivity analysis by population since it would be anticipated that likelihood of the change in enrollment trend would vary by population type. For example, the Aged population has experienced annual enrollment trends in a small corridor of between 1.0% and 2.0% for several years. We have assumed annual growth rates between 1.5% and 2.0% for the Aged population. However, the Children and Adult populations have experienced annual enrollment growth rates between 5% and 20% during the past several years. The wide variation in enrollment growth rates causes more difficulty in the development of projected enrollment trends. The detailed analysis is illustrated in Appendix D.

## **COST CONTAINMENT**

OMPP has implemented several cost containment measures and will be implementing additional measures throughout fiscal year 2003. A summary of the estimated cost containment savings is provided in Appendix E. The summary compares projected expenditures for fiscal years 2001 through 2005 with and without the impact of these cost containment measures. Cost containment savings are illustrated in State only dollars in Appendix E and in the following cost containment sections that highlight a few of the major cost containment initiatives.

## A. Nursing Home

OMPP instituted several nursing home cost containment initiatives in the 2002-2003 biennium. The major changes were implemented as part of the case mix reimbursement system in two phases; the majority of both phases became effective on July 1, 2002 (SFY 2003) due to legal challenges in SFY 2002. A summary of the major initiatives is listed below. It is important to note that these cost containment initiatives are assumed to continue in effect during the 04-05 biennium and are included in this forecast.

- **Inflationary Reduction of 3.3%.** This was scheduled to sunset during FY 2004; however, due to the fiscal situation, OMPP intends to repeal the sunset provision. Therefore, this budget forecast assumes the 3.3% inflationary reduction remains in place. The estimated cost savings/fiscal impact is \$11.1 million for fiscal year 2003 and \$22.3 million for fiscal years 2004 and 2005.
- **Remove Profit Add-on from Direct Care Component.** This provision has a sunset date of June 30, 2004; however, due to budgetary pressures, OMPP intends to repeal the sunset provision. Therefore, the removal of the direct care profit add-on is built into the 04-05 budget forecast. The estimated cost savings/fiscal impact is \$11.3 million for fiscal year 2003 and \$22.7 million for fiscal years 2004 and 2005.
- **Minimum Occupancy Standard.** Effective July 1, 2002, OMPP implemented a 65% minimum occupancy standard for nursing facilities. OMPP will be increasing the occupancy standard to 75% in 2003, 85% in 2004 and 90% in 2005. The estimated cost savings/fiscal impact is \$3.5 million in fiscal year 2003 and \$22.9 million in fiscal years 2004 and 2005.

## B. Pharmacy

- **Preferred Drug List.** The Preferred Drug List (PDL) is being implemented on a monthly basis by therapeutic drug class. The first class was implemented in August 2002. The budget projection reflects the drug classes that have been or are expected to be implemented by June 2003. If additional classes are implemented, the cost savings estimate will be updated to reflect additional potential cost savings. To estimate the cost savings, based on the emerging experience, we have assumed for all drug classes that 95% of the non-preferred drug prescriptions will be switched to preferred drug prescriptions. While the state savings have been adjusted by the OBRA '90 rebate of 21%, we have not included any impact to the rebate to reflect a potential change in the amount due to different rebates associated with different products. The estimated cost savings/fiscal impact is \$3.9 million in fiscal year 2003 and \$18.5 million in fiscal years 2004 and 2005.
- **Change to Pharmacy Reimbursement and Increase in Co-Pay.** Effective in June of 2002, OMPP changed pharmacy reimbursement to average wholesale price (AWP) – 13.5% for brand name drugs and AWP - 20% for generic drugs. A State Maximum Allowable Cost (MAC) fee schedule has also been implemented, which provides a MAC rate for drugs that are not included on the federal MAC schedule. In July 2002, the co-payment for brand name drugs was increased to \$3.00. Co-payments for generics were unchanged, at \$.50 per generic prescription. The estimated cost savings/fiscal impact is \$15.4 million in fiscal year 2003 and \$39 million in fiscal years 2004 and 2005.

### **C. Repeal of Continuous Eligibility**

The twelve-month continuous eligibility provision for children was removed effective July 1, 2002. Removal of continuous eligibility is expected to result in a reduction of 39,737 enrollees from the Children population. Adverse selection for the remaining Children enrollees is expected to slightly offset the savings. The estimated cost savings/fiscal impact is \$15.8 million in fiscal year 2003 and \$45.1 million in fiscal years 2004 and 2005.

### **D. Medicare Crossover Reimbursement**

Effective July 2002, Medicaid changed its reimbursement policy for Medicare crossover claims for non-Long Term Care services. The non-Long Term Care services include, but are not limited to, Hospital Inpatient, Hospital Outpatient, Physician, and Ancillary service providers. This policy change affects reimbursement for Medicaid recipients who are dually eligible for both Medicaid and Medicare (i.e., Aged, Blind and Disabled Dual eligible and Partial Eligible populations). This policy change limits Medicaid reimbursement for dually eligible recipients to the Medicaid rate. In other words, if the Medicare rate is higher than the Medicaid rate, Medicaid will only reimburse up to the Medicaid rate. This is consistent with how Medicaid treats all other third party coverage. In addition to the non-Long Term Care Medicare Crossover claims, Medicaid changed the reimbursement policy for Long Term Care crossover claims (nursing home claims) effective May 1, 2002.

Please note that hospitals and nursing homes can recover a portion of this reduction on their Medicare bad debt cost reports. The table below shows the cost savings from re-pricing both long term care and non-long term care crossover claims.

<b>Fiscal Year</b>	<b>State Savings (Millions)</b>	
	<b>Non-Long Term Care</b>	<b>Long Term Care</b>
2002	\$0.0	\$1.2
2003	22.9	7.6
2004	25.2	7.6
2005	27.6	7.6

### **E. Mandatory Risk Based Managed Care**

Mandatory risk based managed care was implemented throughout fiscal years 2002 and 2003 for the Adult, Children and CHIP populations. The estimated cost savings/fiscal impact is \$3.6 million in fiscal year 2003 and \$14.7 million in fiscal years 2004 and 2005.

### **F. Dental Cap & Other Dental Policy Changes**

For adult recipients, OMPP is implementing an annual \$600 dental cap, with an expected mid-January 2003 effective date. Through collaborations with dental providers, OMPP agreed to carve oral surgical services and certain periodontal services out of the cap, meaning they do not count toward the \$600 annual expenditure. In order to be able to carve those services out of the cap, OMPP is making other policy changes to achieve the necessary cost savings. The estimated cost savings/fiscal impact is \$1.5 million in fiscal year 2003 and \$17.7 million in fiscal years 2004 and 2005.

## **F. Asset Sheltering / Eligibility Loopholes**

During SFY's 02 and 03, OMPP adopted rules that would reduce or eliminate some of the most abusive Medicaid planning techniques, including:

- The purchase of "Medicaid-friendly" balloon annuities
- Shelters involving income-producing real property
- The purchase of U.S. Savings Bonds to exploit the six-month retention period
- Expansion of estate recovery to include non-probate assets

The cost savings from these rules is estimated at \$7.3 million annually; however this does not include the savings bond rule and some of the savings will occur at point of eligibility and are therefore difficult to quantify. Lastly, although legislation was passed that grants the state lien authority in certain cases, due to the \$125,000 exemption included in the statute, OMPP does not expect to recognize any cost savings.

## **TRENDS - MAJOR CATEGORIES OF SERVICE**

The top three expenditures in the Medicaid program are nursing home (22%), pharmacy (17%) and hospital (15%) (SFY 2002). This section highlights the projected utilization and costs for these major categories of service. These values reflect only the fee-for-service and PCCM programs (additional amounts are expended on pharmacy and hospital services through the risk based managed care program but they are not reflected in these numbers). Mandatory risk based managed care and capitation payments as well as home and community based waivers are also included in this section as they are growing components of the Medicaid budget. Appendix F provides a chart showing the distribution of expenditures by categories of service.

### **A. Nursing Facility**

Nursing facility expenditure growth was reduced in SFY 2003 due to the cost containment initiatives. The 04-05 forecast assumes a slight decrease in nursing facility bed days and continued increases in average cost per bed day. Total nursing facility expenditures are expected to grow 2.5% and 5% in state fiscal years 2004 and 2005, respectively.

### **B. Hospital**

For 04-05 inpatient hospital trends, we are projecting a decrease in utilization but an increase in cost per unit of service that outpaces the decreased utilization. For outpatient hospital trends, we are projecting increases in both utilization and costs at higher rates of growth for this biennium given the national trends. In addition, we continue to experience shifting of some inpatient utilization to the outpatient setting. Inpatient and outpatient combined are projected to grow 9-11% during the 04-05 biennium. The negative growth experienced in 2003 was the result of the cost containment that was enacted.

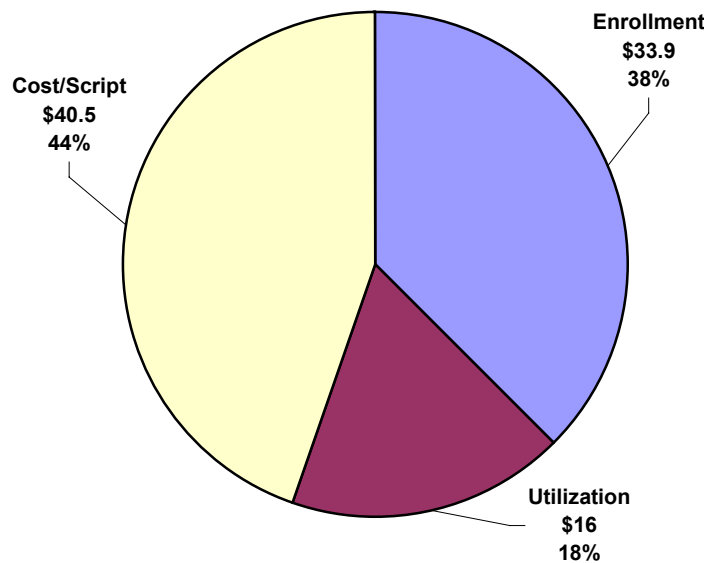
### **C. Pharmacy**

Pharmacy expenditure growth is a combination of utilization and costs. A summary of historical utilization, average reimbursement and per member per month costs for Pharmaceutical services for fiscal years 2000 through 2002 is shown below. The data shows that:

- The number of prescriptions per 1,000 has been increasing by an average rate of 1.5% to 5.0% per year.
- The cost per drug has increased by 6% to 15% during the prior two fiscal years.
- Overall, per member per month pharmacy costs have increased by 8.5% to 18.8% from fiscal year 2001 to fiscal year 2002.

From SFY 2003 to 2004 pharmacy expenditures are projected to increase from \$642.9 million to \$733.3 million. The components of this \$90.4 million increase are illustrated below.

### Components of Pharmacy Growth Projected SFY 2004



Note: The projected component percentages for SFY 2005 are 31%, 14%, and 55% for enrollment, utilization, and cost/script respectively.

For the upcoming biennium, total pharmacy expenditures are projected to be \$733.3 million in SFY 2004 and \$865.7 million in SFY 2005, representing growth of 14.1% and 18.0% respectively. The highest pharmacy costs are in the aged, blind and disabled aid categories. Their projected per member per month pharmacy costs for SFY 04 are expected to average approximately \$323 compared to an average PMPM of approximately \$71 for adults and approximately \$26 for children. Of total pharmacy expenditures, over 80% is spent on aged, blind and disabled recipients, which represent only roughly 20% of total Medicaid enrollment.

#### **D. Managed Care**

In summarizing historical data, capitation payments made to the managed care organizations have been illustrated as a separate service category from the other non-long term care services. In addition to the capitation payments, we have included the Primary Care Case Management (PCCM) payments. In the TANF and CHIP populations, the PCCM administration fee is \$3 per member per month. The PCCM administration fee for the new Medicaid Select program for the Aged, Blind and Disabled population is \$4 per member per month. In developing projected budgets for fiscal years 2002 through 2005, the number of managed care enrollees and the related capitation payments are projected separately from the non-long term care services. The

forecasted expenditures shown in Table 6 include PCCM fees and capitation payments and demonstrate that managed care is becoming a larger part of the Medicaid program and budget.

**Table 6**  
**Capitation Payment and PCCM Fee Expenditure Forecast**

**Total Expenditures in Millions**

<b>Population</b>	<b>FY 2002</b>	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>
Aged	\$0.0	\$0.1	\$0.7	\$0.8
DAB Non-Dual (1)	0.0	0.3	1.9	2.1
DAB Dual	0.0	0.1	0.7	0.7
<b>Total Aged, Blind &amp; Disabled</b>	\$0.0	\$0.5	\$3.3	\$3.5
Adults	\$61.0	\$103.3	\$117.0	\$130.1
Children	145.1	217.7	234.1	252.2
CHIP I	10.2	16.0	17.3	18.6
CHIP II	2.2	4.6	5.8	6.9
Mothers	15.3	30.7	32.9	34.5
<b>Total TANF &amp; CHIP</b>	\$233.8	\$372.3	\$407.1	\$442.4
<b>Total All Populations</b>	\$233.8	\$372.9	\$410.4	\$445.9

**E. Home and Community Based Waivers**

Table 7 illustrates projected expenditures in the Home and Community based waiver programs. Indiana has seven home and community based waivers:

- Traumatic Brain Injury
- Medically Fragile Children
- Autism
- Developmentally Disabled
- Aged and Disabled
- Assisted Living
- Support Services

The increase in future expenditures results from an increase in the number of waiver slots available that are funded through the Medicaid program. The largest increase has occurred in the Developmentally Disabled and Support Services waivers.

**Table 7**  
**Waiver Expenditure Forecast**

**Total Expenditures in Millions**

<b>Waiver</b>	<b>FY 2002</b>	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>
Traumatic Brain Injury (TBI)	\$2.6	\$3.3	\$4.6	\$5.7
Medically Fragile Children	1.5	1.7	1.7	1.8
Autism	7.2	11.7	18.1	24.1
Aged and Disabled	20.4	30.7	40.5	43.1
Developmentally Disabled	142.2	201.2	247.6	290.0
Assisted Living	0.0	0.4	0.7	0.8
Support Services	1.4	27.8	52.9	66.2
<b>Total</b>	\$175.3	\$276.9	\$366.2	\$431.7

## **CHILDREN’S HEALTH INSURANCE PROGRAM**

The Children’s Health Insurance Program (CHIP) was authorized in 1997 for a period of ten years. Indiana implemented CHIP in two phases. The first phase, CHIP I, is a Medicaid expansion. It began in July 1998 and expanded enrollment for all children through age 18 up to 150% of the Federal Poverty Level. The second phase, CHIP II, is considered a separate program by the federal government because the benefits are different from Medicaid, although the two programs are seamlessly integrated. It began in January 2000 and expanded eligibility for children to 200% of the Federal Poverty Level.

Federal CHIP allotments are distributed annually to states, and states have three years to spend the allotment. States that do not spend their annual allotment within the three-year timeframe must return the unspent funds. Some of these funds are then redistributed to the states that have spent all of their annual allotment. Indiana received \$45 million in the redistribution of remaining 1998 funds and \$105 million in redistributed 1999 funds.

States receiving redistributions were given the option to select the order in which they would spend their remaining allotments and the redistribution funds. To maximize funding, Indiana chose to first spend any expiring annual allotment then the redistribution funds. A summary of Indiana’s federal funding and the order of expenditures is provided in Table 8.

**Table 8**  
**Indiana CHIP Federal Funding**

<b>Order of Expenditures</b>	<b>Amount</b>	<b>Status</b>
1998 allotment	\$70 M	Spent all
1999 allotment	\$70 M	Spent all
1998 <i>redistribution</i>	\$45 M	Spent all
2000 allotment	\$63 M	\$13 M reverted 10/1/02
1999 <i>redistribution</i>	\$105 M	All reverted 10/1/02
2001 allotment	\$61 M	Began spending 10/1/02
2002 allotment	\$47 M	
2003 allotment	\$57 M	
2004 allotment	\$47 M	
2005 allotment	\$61 M	
2006 allotment	\$61 M	
2007 allotment	\$61 M	

The redistribution formula was established under the Benefit Improvement and Protection Act of 2000 (BIPA). BIPA addressed the redistribution methodology for the 1998 and 1999 annual allotments, allowing redistribution states two years to spend the 1998 redistribution and one year to spend the 1999 redistribution funds. Hence, Indiana had until September 30, 2002 to spend the \$105 M redistribution funds. FSSA sought an 1115 waiver to use some of the 1999 redistribution funds; however, that waiver was denied by the Center for Medicare and Medicaid Services (CMS) in May of this year. Because Congress did not pass legislation to extend the benefits of BIPA, the \$105 M reverted before Indiana could spend any of the extra funds.

As shown in Table 9, Indiana is now expending the federal allotments more quickly than when the program first began. This is due in part to the “CHIP Dip”, a decrease in the federal award over FFY 2002-2004. We have estimated that in State fiscal year 2008, Indiana will exceed the Federal allotments. If the 1999 redistribution funding is restored to Indiana, the \$105 M could be used to supplement the decreased federal funding during the CHIP Dip (2002-2004), and extend the number of years that federal funding is available to provide health coverage through CHIP. A chart illustrating the state fiscal years in which each federal award was spent is included in the appendix.

**Table 9**  
**Expenditure of CHIP Allotment**

<b>Federal Fiscal Year</b>	<b>Reversion Date</b>	<b>Allotment (millions)</b>	<b>State Fiscal Year Expended</b>
2001	9/30/2003	\$61.0	SFY 2004
2002	9/30/2004	47.0	SFY 2005
2003	9/30/2005	57.0	SFY 2006
2004	9/30/2006	47.0	SFY 2006
2005*	9/30/2007	61.0	SFY 2007
2006*	9/30/2008	61.0	SFY 2007

Note: \* Estimated amount, the allotment has not been established for these two fiscal years.

## **LAWSUITS**

### **A. Day Update**

In June of 2001, the State lost the Petricia Day lawsuit, a class action suit filed in 1993, which resulted in OMPP no longer denying Medicaid disability eligibility solely because the individual's disability may improve with treatment. Potential class members had until July 12, 2002 to certify themselves as part of the class. Of the approximately 18,000 potential class members, 3,871 members actually became certified as part of the Day case. Those 3,871 class members have until August 11, 2003 to present claims for Medicaid eligible services provided to them during the period they were found to be ineligible due to the standard explained above. Based on the final number of class members, OMPP has estimated a potential fiscal impact of \$50 M state dollars, with the majority of expenditures occurring in SFY 2003.

### **B. Collins Lawsuit (Collins vs. Hamilton)**

In September of 2002, the U.S. District Court, Southern District of Indiana found that Indiana's Medicaid program violates federal Medicaid law by refusing to cover long-term residential treatment for Medicaid patients under 21 for whom such mental health treatment has been found medically necessary. The court ordered Indiana Medicaid to provide Medicaid-eligible children under 21 with psychiatric residential treatment facility (PRTF) services when found necessary by Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening examinations. The State is appealing this case and was granted a stay upon appeal. OMPP is in the process of estimating the fiscal impact of this lawsuit should the state lose on appeal.

### **C. Hospital Care for the Indigent (HCI) (Griffin v. DLGF)**

This case challenges the constitutionality of the HCI tax. The Tax Court found in favor of the taxpayer. The State appealed, and the appeal is pending in the Supreme Court. Oral arguments were held October 2002, and we are awaiting the Supreme Court ruling. The estimated fiscal impact is \$48 million (state dollars).

**D. Kraus v. Hamilton (formerly Bennett v. Humphreys)**

This case was filed in St. Joseph Superior Court December 2000. Plaintiffs are seeking class certification and are persons with developmental disabilities claiming the operation of the Indiana Medicaid program violates the Americans with Disabilities Act (as interpreted by the U.S. Supreme Court in Olmstead) because plaintiffs allegedly have not received services in the least restrictive setting appropriate to their needs. If plaintiffs prevail, state could be ordered to fund significant expansion of services. At this point, the fiscal is unknown.

**E. Amhealth v. FSSA**

This case was brought against the State by nursing homes challenging the emergency rulemaking procedure followed in implementing Phase I nursing home cost containment. Plaintiff nursing homes obtained an injunction to prevent OMPP from enforcing Phase I emergency rules on October 1, 2001. The case is pending in Indiana Court of Appeals. The fiscal impact is \$12 million (state), which represents the amount lost by not realizing the anticipated savings from the emergency rules.

**F. D&M Healthcare, Inc. v. O'Bannon**

This case was filed by nursing homes in Marion Superior Court May 2002. Plaintiff nursing homes seek declaratory judgment and permanent injunction to prevent FSSA from enforcing and implementing changes to NF reimbursement (Rule 14.16, Phase I changes). The complaint has since been amended to include OMPP's Phase II nursing home rule changes. If the plaintiffs prevail, OMPP would have to reinstate the reductions made through Phase I and Phase II nursing home cost containment, which would result in approximately \$41 M in lost savings (state) for SFY 02 and 03 and would also prevent OMPP from recognizing ongoing savings in 04 and 05.

**RISKS TO THE FORECAST**

In addition to the enrollment sensitivity and lawsuits already mentioned, another risk is forecasting limitations. This forecast relied upon paid claims data through October 31, 2002. To the extent that the incurred claims data was not complete, the values presented in the forecast may be revised at a later date when more complete data is available. As with any incurred forecast, actual expenditures may be higher or lower than currently projected.

Two additional risks are legislation and cost containment. If legislation is passed that either expands the Medicaid program or otherwise mandates changes that result in additional expenditures, this forecast will increase. Similarly, if cost containment measures that have been enacted are repealed, either legislatively or due to litigation, total Medicaid forecasted expenditures would increase.

## **APPENDIX**

- A Expenditure Forecast: SFYs 2000-2005
- B Funding Sources: SFY's 2002-2005
- C Expenditure Trend: SFY's 2001-2005
- D Enrollment Sensitivity Analysis
- E Cost Containment Savings Summary
- F Expenditures by Category of Service: SFY 2002
- G CHIP Expenditures: SFY's 2001-2008